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ABSTRACT

This monograph concerns the the issue of adolescent suicide and discusses counseling and intervention techniques to prevent suicide among teenagers. Fourteen myths and misconceptions about suicide are explained. A profile of a potential suicide attempter is presented, and issues of behavioral indications, verbal cues, motivations and cognitive distortions, depression, and personality traits are discussed. The rationale for choosing a cognitive-behavioral approach to counseling aimed at preventing adolescent suicide is given and six intervention strategies are suggested. Six components of school-based suicide prevention programs which must be in place for the adolescent at-risk population are identified: (1) district and building level administrative support; (2) faculty/staff inservice on the topic of adolescent suicide; (3) parent education on adolescent suicide; (4) classroom presentations for all adolescents; (5) preparation of core teams; and (6) options for individual and group counseling. Crisis management is considered and questions useful in assessing lethality are posed. Crisis management interventions are discussed, postvention is described, and follow-up counseling or therapy is recommended. References are included which can provide further information on the topic of counseling and intervention strategies for working with adolescents at risk for suicide. (NB)

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COUNSELING AND INTERVENTION STRATEGIES FOR ADOLESCENT SUICIDE PREVENTION

Dave Capuzzi

CG 020492

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COUNSELING AND INTERVENTION STRATEGIES FOR ADOLESCENT SUICIDE PREVENTION

by

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TABLE OF CONTENTS

Page

About the Author iii

Introduction and Problem Overview 1

Common Myths and Misconceptions 2

Profile of the Potential Attempter 5
- Behavioral Indications 5
- Verbal Cues 8
- Motivations and Cognitive Distortions 8
- Depression 10
- Personality Traits 10

Prevention 12
- Counseling as Prevention 12
- Intervention Strategies 13
- Prevention Strategies for Schools and Communities 15

Crisis Management 19
- Assessing Lethality 19
- Crisis Management Interventions 23

Postvention 25
- Coping with the System 25
- Facilitating Follow-up Counseling or Therapy 26

Some Final Notations 27

References 29

ABOUT THE AUTHOR

Dave Capuzzi, Ph.D., is Past President of the American Association for Counseling and Development and Professor of Counselor Education at Portland State University in Portland, Oregon. Prior to affiliating with Portland State University in 1978, he served in faculty positions at Florida State University, Our Lady of the Lake University of San Antonio, and the University of Wyoming.

Dr. Capuzzi's publications have appeared in journals such as *Counselor Education and Supervision*, *Counseling and Values*, *Humanist Education and Development*, and the *Journal for Specialists in Group Work*. From 1980 to 1984, he served as editor of *The School Counselor*. Dr. Capuzzi has authored a number of textbook chapters and monographs on the topic of preventing adolescent suicide and was co-editor and author, with Dr. Larry Golden, of *Helping Families Help Children: Family Interventions with School Related Problems*, 1986, and *Preventing Adolescent Suicide*, 1988.

Dr. Capuzzi has won a number of awards for his contributions of service and expertise to professional groups. Among these are the Human Rights Award of the South Carolina Association for Counseling and Development, the Leona Tyler Award of the Oregon Counseling Association, the Outstanding Service Award of the Western Region of the American Association for Counseling and Development, and the Silver Award for Editorial Excellence of the Society of National Association Publications.

A frequent speaker for professional conferences and institutes, Dr. Capuzzi also has consulted with a variety of school districts and community agencies interested in initiating counseling and intervention strategies for the prevention of adolescent suicide. He has facilitated the development of suicide prevention, crisis management, and postvention programs in communities in twenty-three states.

Introduction and Problem Overview

Adolescent suicide is the second leading cause of death among the 11-to-24 age group. Although adolescent suicide is a worldwide problem, only in the United States has the situation reached epidemic proportions (Hafen & Frandsen, 1986; Joan, 1986). According to recent estimates, one teenager attempts suicide every 90 seconds and one completes the act of suicide every 90 minutes (Hafen & Frandsen, 1986). Although statements such as "7000 teenagers each year commit suicide, while an additional 400,000 try unsuccessfully to end their own lives" (Hafen & Frandsen, 1986) are common, many experts (Curran, 1987) warn that statistics are not accurate and that the incidence of adolescent suicide attempts and completions is seriously underestimated. According to data available through the Division of Vital Statistics of the National Center for Health Statistics and the Bureau of the Census (Hafen & Frandsen, 1986), suicide rates among 15-to-24 year-old adolescent women increased 200 percent during the past 25 years. The rates for adolescent men in the same age range is higher, increasing 300 percent in the past 25 years. Adolescent women who complete the act of suicide now comprise 15 percent of all suicides in the United States each year; adolescent men who complete suicide comprise almost 20 percent of the total. The suicide rate of adolescent men in the United States now surpasses that of all other countries in the world including Japan and Sweden which have long been identified as having a problem with suicide (Hafen & Frandsen, 1986).

There has been much speculation and considerable study of the parameters connected with adolescent suicide. Adolescence as a stage in psychosocial development has become more prolonged, more complex and more difficult. One of the essential developmental tasks of adolescence is to separate and develop an identity, a sense of purpose and a system of values. This identity can only exist, however, in relation to someone or something else. As adults have become more and more focused on earning a living in a society in which the cost of goods and services has escalated more rapidly than salaries, less time has been available for the parenting, role modeling and nurturing activities so necessary to the well-being of the adolescent family member. Adolescents become disillusioned as political and religious leaders (e.g., Gary Hart, Jim and Tammy Bakker) and notable media luminaries (e.g., Rock Hudson) lose credibility because of their behavior or societal prejudice. Adolescents of the 1980s question the emphasis on increased education and vocational preparation which lengthen the period of adolescence and produce an over-abundance of choices. Many are apprehensive about their futures in a society in which the economy and

quality of life may be declining; some experience high stress in relation to what they perceive as the ever-present threat of nuclear annihilation. An ever-growing concern is the proliferation of the means and acceptability of avoidance as a means of coping (Curran, 1987). This avoidance includes use and abuse of alcohol and other substances, sexual acting out, running away, dropping out of school and developing eating disorders. Adolescents who turn towards such behavior are easily delayed in their ability to develop decision making, communication, problem solving and stress management skills so necessary to constructive coping in an increasingly complex society.

One final notation must, of necessity, be made. Adolescents are very much aware of the incidence of adolescent suicide in this country. Even if an adolescent is fortunate enough to have never been exposed to a friend or family member who has attempted suicide or grieved by the loss of someone who has completed suicide, radio, television and newspaper coverage of individual or cluster suicides is something which constantly bombards adolescents. Vulnerable adolescents are not likely to analyze the consequences of a suicidal gesture that is carried through to completion if media coverage emphasizes the sensationalism of the act or romanticizes the motivations which led to such desperate behavior. Over and over they are exposed to the suicides of adolescents from all parts of the country. Since people learn, in part, by imitating behavior which is modeled and since peer group influence is so important during the adolescent years, more and more adolescents may view peers who took their lives as the heroes they no longer find in the world of the independent adult.

Common Myths and Misconceptions

As noted by Johnson and Maile (1987), it is important for every counselor to correct common myths and misconceptions connected with the topic of suicide. To be an effective intervener, whether in the contexts of prevention, crisis management or postvention, it is important to know the facts and avoid the myths.

Suicide is inherited. Suicide is not inherited; it is not a genetic trait. However, since families share the same emotional climate and since coping skills are modeled by parents and often adopted by children, suicide can be more prevalent in some families than in others. Just as the son or daughter of an abusive parent may be abusive in his or her interpersonal relationships as a means of reducing stress, so might the son or daughter of a

parent who attempted or completed suicide view suicide as a problem solving option (Hafen & Frandsen, 1986).

Suicide is a rich or poor person's curse. This, also, is not true. Suicide is evenly distributed among socioeconomic groups.

Most suicides occur in bad weather, the spring, during holiday periods, or at night. Suicide can occur any time. Professionals and concerned friends and family members must not assume that there is no danger because it isn't a holiday or that bad weather will make a depressed individual suicidal. Suicide probability must be assessed in relation to the behavior and circumstances of the at risk individual.

Those who commit suicide are psychotic or mentally ill. Although the risk of suicide increases if there is psychosis or mental illness, many suicidal individuals are depressed and have a history of difficulty in coping with their problems. A "normal" person who can't figure out any other way of putting a stop to the pain of trying to cope may choose suicide as an option.

Once a person is suicidal, he or she is suicidal forever. Most adolescents who become preoccupied with suicidal thoughts are suicidal for only a limited period of time. Many can go on to lead normal lives once they work through the suicidal crisis, especially if they improve their ability to cope with the complexities of life. The best prognosis occurs for those who only think about suicide but do not attempt it.

Improvement following a suicidal crisis means the risk is over. This is a dangerous assumption, especially if the improvement is sudden (overnight, for example) and circumstances remain unchanged. Many adolescents experience a change in energy and a lessening of depression after a suicidal crisis which leads them to develop a plan and finalize the decision. Stress may be lowered, and improved communication ability may mislead friends, family members and others into thinking the risk has been lowered when in fact the risk may be higher than ever.

Suicidal adolescents are intent on dying. Suicide has often been labeled as a "cry for help." Adolescents who are experiencing difficulty with school, family and friends may be in so much pain that they view a suicide attempt as the best option for decreasing that pain and reaching out to others. A combination of life circumstances, low self-esteem and a history of difficulty with problem solving may make it difficult to let peers or adults know they are in need of assistance; suicidal behavior may be a desperate plea for attention.

Adolescents who talk about suicide are simply trying to attract attention; adolescents who really commit suicide don't talk about it. Almost everyone who commits suicide has

given others a variety of cues; some adolescents give verbal as well as behavioral cues. You must not assume that an adolescent who openly talks about suicide is not at risk.

Suicide happens without warning. Adolescents may not give explicit verbal or behavioral cues, but some cues are always there. The problem is that most people do not know how to recognize the signs and symptoms so that the suicide appears to have happened without warning.

Talking or asking about suicide with an adolescent may increase the risk of suicide. Many adults mistakenly believe this myth. It is unlikely that the nonsuicidal adolescent would become preoccupied with suicidal thoughts because someone talked about suicide or used the word. It is quite probable that a suicidal adolescent would feel a sense of relief if an adult seemed to sense the depth of pain being experienced and asked if suicidal preoccupation had become an issue. Many adolescents assume that their secret thoughts about suicide would be too difficult to express or too alarming to the listener. Well-prepared counselors and other helping professionals who address the issue through well-presented programs on the topic or through supportive one-to-one interactions can give adolescents the "permission" they need to ask for assistance.

If an adolescent attempts suicide and survives, he or she probably won't make an additional attempt. Four out of five individuals who complete the act of suicide have made at least one previous attempt (Hafen & Frandsen, 1986). The prognosis for recovery is not as good with an adolescent who enters counseling or therapy after an attempt as it is for an adolescent who begins treatment prior to actually going through with a suicidal plan. Adults (and peers) must closely monitor the adolescent attempter for a period of months (or years, depending on the individual and the circumstances) after an attempt and make sure that counseling is available and continues to be available during difficult periods.

The most common method of suicide is drug overdose. This is not true. The leading method of completing the act of suicide is the use of guns. Drugs and poisons (e.g., carbon monoxide) are often used but increase the probability of medical intervention in time. Gun shot wounds are more instantaneously lethal.

Every adolescent who commits suicide is depressed. Depression is commonly linked to suicide, but not every suicidal adolescent is depressed. Some adolescents simply are unable to cope with their life experiences as perceived and choose suicide as a way to escape.

Confidentiality must be maintained if you learn of an adolescent's suicidal intentions. This is definitely false and a very dangerous assumption. The Code of Ethics of both the

American Association for Counseling and Development (1981) and the American Psychological Association (1981) specify that confidentiality is not to be maintained when an individual is a danger to self or others. When minors are involved, parents should immediately be notified of suicidal intention so that intervention can be immediate. Suicidal adolescents should never be promised total confidentiality and usually respect the actions of a professional who understands how to approach such a situation. The liability issues that could arise in a situation in which the parents were not informed about the suicidal intentions of their child, as well as the moral obligation to intervene to prevent an attempt and to abide by ethical guidelines that are available, make any promise of total confidentiality inappropriate.

Profile of the Potential Attempter

The circumstances connected with every suicide attempt (or completion) are unique because every adolescent has experienced a unique family and social history. Sometimes an adolescent will provide a limited number of cues to family members, peers, teachers, etc.; sometimes dozens of cues will be given by a teenager preoccupied by thoughts of suicide. It is important for adults (and young people as well) to recognize the warning signs and symptoms which precede an attempt or a completion so that they can respond to an adolescent who is becoming more and more stressed and desperate. Comments of parents and teachers such as "I never expected a suicide attempt," or "I saw him two weeks ago and he was just fine," simply mean no one was aware of the warning signs. Experts believe that 90 percent of the adolescents who commit suicide (and first attempts often result in completions) give clues to others first (Curran, 1987; Davis, 1983; Hafen & Frandsen, 1986; Husain & Vandiver, 1984; Johnson & Maile, 1987).

Behavioral Indications

Lack of concern about personal welfare. Some adolescents become unconcerned about personal welfare and safety. Careless driving, taking risks while crossing streets and poor judgment about walking alone at night may all be ways of attempting to let others know, "I don't matter and am not important enough to care whether my life goes on or not."

Changes in social behavior. As adolescents become more and more preoccupied with suicidal thoughts, their social behavior may begin to change. An outgoing, sociable adolescent may begin to withdraw, hesitate to converse with family and friends, and drop out of previous involvement in school-related activities. A cooperative, positive teenager may suddenly seem rebellious, nonconforming and generally negative about life. A meticulous teenager may suddenly start leaving clothes, books, dishes, etc. strewn all over the house. Relatively sudden changes in long-established social patterns can be a strong cue that a young person is beginning to feel desperate and hopes someone will notice.

A decline in school achievement. Although every adolescent can be expected to encounter a difficult subject, teacher or classroom situation periodically, a rapid disengagement from the academic experience and a loss of interest in completing assignments and studying may be a strong suicidal cue. It does not make sense for an average or a good student to suddenly reject the school experience. The key to assessing such a set of circumstances is the length of time the decline lasts.

Marked difficulties with concentration and thinking clearly. An adolescent may become so preoccupied with internal pain that he or she cannot concentrate on any task, activity or conversation. It may become more and more obvious that the adolescent's attention span is shorter and that verbal comments bear little relationship to the topic of a conversation. Reasoning and thinking patterns may become more and more confused.

Altered patterns of sleeping and eating. As the risk of a suicidal attempt or completion escalates, adolescents may drastically alter sleeping or eating patterns. These changes can vary from not being able to sleep at all, to wanting to sleep all the time or all day, to roaming from room to room in the house at night. Sudden increases or decreases in weight may follow marked changes in appetite. Such altered patterns offer strong cues that something is wrong and assistance is needed.

Attempts to put personal affairs in order. Suicidal adolescents, like adults, often decide to put personal affairs in order especially after a suicide "decision" has been made. Projects may be completed, troubled relationships may be "smoothed," old friendships may be reinstated or prized possessions may be given away (sweaters, collections, video cassettes, jewelry, etc.)

Drug or alcohol use or abuse. Many troubled adolescents use and abuse alcohol and other drugs in an attempt to assuage their feelings of loneliness and

hopelessness and take charge of their lives. Unfortunately, drug involvement decreases the likelihood of being able to communicate or improve problem solving. Thinking patterns become more confused and impulse control may be lessened. A rapid onset of involvement with controlled substances (or over-the-counter drugs which can be abused) is a strong indicator of difficulty with coping with day-to-day interactions and responsibilities.

Intense interest in how others are feeling. Sometimes adolescents who are becoming suicidal develop an intense interest in how others are feeling. This may become an all-consuming pastime and can serve to lessen preoccupation with self as well as communicate to others, "I wish you would ask me how I am feeling."

Preoccupation with themes of death and violence. Suicidal adolescents often become focused on thoughts of death and violence. They may talk about what death may be like, plan their own funerals, read poetry or books in which death, suicide or violence is the predominant theme, or listen to music which conveys a death wish. Some teenagers may write stories, draw, sketch or watch movies in which death, suicide or violence to self or others is the apparent theme. These adolescents may be undecided about whether to choose life or death and trying to make a decision.

Sudden improvement after a period of depression. Sometimes friends and family members are fooled when an adolescent who has been depressed, having trouble sleeping, eating differently, withdrawn, etc. seems to drastically improve, sometimes in less than a 24-hour period. Although parents and others feel encouraged by this positive behavior and seeming change for the better, the suicidal crisis may be peaking and an act of self-destruction may be imminent. Quite often, when the decision about suicide has been made and a plan formulated, depression lifts as stress, uncertainty and feelings of powerlessness decline. The important point to remember is that it is not logical for a depressed adolescent, who has probably exhibited the signs of depression for weeks or months, to suddenly improve. It takes time and effort to improve coping ability and lessen feelings of depression, just as it took time to develop nonadaptive responses to circumstances and depressive feelings of hopelessness and despair.

Sudden or increased promiscuity. Sometimes suicidal adolescents who have not been particularly promiscuous or engaged in any sexual experimentation do so as suicidal preoccupation increases. Such experiences may serve to temporarily refocus attention or symbolize escalating feelings of resentment towards circumstances perceived as intolerable or out of control.

It should be noted, as stated earlier, that since adolescents are all unique, the observable behavioral changes during a suicidal episode will also be individualized. Anyone concerned about an adolescent should assess current behavior in the context of established patterns and in conjunction with verbal cues, motivations and cognitive distortions, depression, and personality traits.

Verbal Cues

Adolescents at risk for suicide often provide verbal cues to impending self-destructive behavior (Schneidman, Farbverow, & Litman, 1976) which can be assessed in relation to behavioral indications. "I won't have to worry about school much longer," "You'll be sorry for what you've done," "I wish I were dead," "I'm going home," "If [such and such] happens, I'll kill myself," "The only way out is to die," and "I wonder what dying is like" are all examples of verbal cues.

These verbal cues may be given at unexpected times and also may be quite indirect. The following case provides an illustration: Just as the weekend was beginning on a Friday afternoon, a 19-year-old university sophomore called the counseling center where the counselor had seen him for an intake interview a few days before. The client said something like, "You won't be seeing me around for my next appointment with you." Initially, the counselor thought the client had decided to cancel the appointment or perhaps take some "time-out" from the university setting. After encouraging the client to clarify what he meant by, "You won't be seeing me around . . .," the counselor determined that his depression had escalated and that he had decided to end his life over the weekend. The verbal cue was indirect but represented an attempt to obtain some long-overdue help with his problems. Fortunately, a successful intervention was made which included a suicide watch and immediate initiation of long-term counseling focused on primary issues and related dysfunctional behavior. The important thing to remember in such a situation is that when a client (or adolescent family member, friend or student) says something that could be interpreted several ways, one should ask for clarification and follow up on subsequent cues. Careful listening could mean the difference between life and death.

Motivations and Cognitive Distortions

In addition to behavioral indicators and verbal cues, underlying motivations and cognitive distortions make a suicidal adolescent different from the nonsuicidal. One of the

ways to find out about the motivations and possible cognitive distortions of an adolescent seemingly at risk for suicide is to encourage self-disclosure. Suicidal adolescents' motivation can be better understood when suicide is viewed as fulfilling one of the following primary functions: (1) an avoidance function which protects the individual from pain; (2) a control function through which the adolescent attempts to regain control of self or circumstances; and (3) a communicative function which lets others know there is both a need for help and reduced situational stress (see Capuzzi & Golden, in press).

In conjunction with the three functions of avoidance, control and communication, suicidal adolescents distort their thinking patterns in a number of ways which help make suicide seem like the best or only problem solving option. All-or-nothing thinking, for example, enables an adolescent to see situations as polarized with absolutely no options in between. The choice becomes one of continuing to live midst adverse circumstances with no hope for change, or death. Overgeneralization is another cognitive distortion which permits an adolescent to take a single event and apply it to all other situations. Being turned down for a date, for example, may become evidence for being a loser and for always being turned down, rejected or left out. "I can't get much attention from her" becomes "I'm not likeable and will never get what I want." Rejecting positive experiences and denying that such experiences are important is another cognitive distortion called disqualifying-the-positive. Such an adolescent engages in negative self-talk to such an extent that these statements become the reason the adolescent may attempt suicide to prove that he or she can still take control of life circumstances.

When listening to an adolescent who seems to be showing signs of being vulnerable, one of the following themes may emerge several times during the discussion (Capuzzi, 1986, p. 6). These themes usually result from a cognitive distortion based on the avoidance, control or communication functions:

- Wanting to escape from a situation that seems intolerable (e.g., physical abuse, difficulty at school, drugs, lack of friends).
- Wanting to join a friend or family member who has died.
- Wanting to gain the attention of others.
- Wanting to manipulate others.
- Wanting to be punished.
- Wanting to avoid being punished.
- Wanting to control when death will occur.

- Wanting to end a seemingly unresolvable conflict.
- Wanting to become a martyr for a cause.
- Wanting to punish the survivors.
- Wanting revenge.

Depression

As mentioned earlier in the discussion of myths, not all suicidal adolescents are depressed; however, 60 to 90 percent are. Hafen and Frandsen (1986) have noted that depression in an adult is quite often more recognizable (e.g., the adult is tearful, sad, despondent, hopeless or incapable of functioning as usual). Though many adolescents demonstrate the same reactions as adults, they may also respond to depression by seeming bored, restless, angry, rebellious or delinquent. Those who associate depression with feelings of sadness and worthlessness may not recognize depression in an adolescent who starts skipping classes at school, running away or acting out in some other way.

Given the complexity of being an adolescent in the late 1980s, coupled with the normal ups and downs of the developmental stage of adolescence, it is normal for every adolescent to experience short periods of depression. But when depressive periods become more and more frequent, longer and longer, and of such intensity that the adolescent has difficulty functioning at school and at home, they could be a strong warning sign of suicide potential, especially if other aspects of behavior, verbalization, motivations and cognitive distortions have been observed. It is extremely important for professionals who are working with depressed, potentially suicidal adolescents to ascertain whether a depressed adolescent is experiencing endogenous depression brought about by the individual's inherent body chemistry. Counseling or therapy will have little impact if an adolescent is depressed not because of circumstances or poor coping ability but because of a genetically linked chemical aberration over which the adolescent has no control. Counselors and therapists may need to team with psychiatrists or nurse practitioners so that medication along with counseling can become part of a treatment plan.

Personality Traits

It would be of great benefit to those interested in prevention of adolescent suicide if researchers could specifically describe the personality profile of the suicidal adolescent. An adolescent who fits the "profile" could then be identified as being "at risk" and intervention

could take place. Although no consensus has yet been reached on the expected or typical personality of the suicidal adolescent, researchers have agreed on a number of characteristics which seem to be common to many suicidal adolescents.

Low self-esteem. More research needs to be done on the relationship between low self-esteem and adolescent suicide, but a number of studies (Cull & Gill, 1982; Faigel, 1966; Freese, 1979; Stein & Davis, 1982; Stillion, McDowell, & Shamblin, 1984) have linked low self-esteem to suicide probability. The counseling experience of the author as well as that of other practitioners would seem to substantiate the relationship between low self-esteem and adolescent suicide probability. Almost all such clients have issues with feelings of low self-worth or self-esteem.

Hopelessness/helplessness. A number of studies (Cull & Gill, 1982; Kovacs, Beck, & Weissman, 1975; Jacobs, 1971; Peck, 1983) explored the relationship between adolescent suicide probability and feelings of hopelessness or helplessness. In general, suicidal adolescents feel helpless about their situations and have lost hope of being able to control either their feelings or their circumstances. Most practitioners can support the findings of the research in this area and report that their clients deal with these feelings during the process of counseling.

Isolation. Many suicidal adolescents prefer to be alone or to develop small or limited networks of social support. They do not try to develop a large number of friends. Research by a number of authorities (Hafen, 1972; Kiev, 1977; Peck, 1983; Sommes, 1984; Stein & Davis, 1982) tends to support this concept.

Stress. Suicidal adolescents seem to experience stress to a high degree as well as deficits in their ability to manage stress. Some studies explain this factor in terms of low frustration tolerance (Cantor, 1976; Kiev, 1977).

Acting out. Behaviors such as truancy, running away, experimentation with drugs or sex, etc. are frequently present in adolescents who attempt or complete suicide. As discussed earlier, these traits may be manifestations of depression.

Need to achieve. One observation made by this author is that suicidal adolescents sometimes compensate for feelings of low self-esteem by striving for achievement. This achievement can take place in any modality (e.g., grades, risk taking, athletics, clothes). The reader is cautioned, however, not to make assumptions about suicide probability in relation to all high achievers.

Other-directedness. Most suicidal adolescents are "other" rather than "inner" directed. They tend to develop viewpoints and decisions based on what others think and

tell them instead of what they really think and believe. This trait may also be linked to low self-esteem and contribute to the development of feelings of helplessness and hopelessness and an inability to take control of themselves or the situations they experience.

Guilt. A high percentage of the suicidal adolescents counseled by this author experience strong feelings of guilt. Nothing they are and little that they accomplish seem to measure up to the expectations of significant other adults or peers. These guilt feelings are usually linked with low self-esteem and other directedness.

Prevention

Counseling as Prevention

Although educational and training strategies must be integral parts of any prevention effort, one-to-one and small group counseling or therapy are essential components of all prevention programs. Suicidal adolescents have developed their at risk "profiles" over time, most often beginning during early childhood prior to the elementary school years. Counseling, of necessity, must be planned with a long-term focus and an emphasis on eliminating cognitive rigidity, enhancing self-esteem, improving decision making, and improving communication skills. Such efforts take time and expertise on the part of the professional counselor.

Experts increasingly recommend a cognitive-behavioral approach in counseling or therapy aimed at preventing an adolescent from attempting or completing the act of suicide. Justification for this focus is based on the following:

1. Most suicidal adolescents are depressed. Depressed clients need to experience changes in behavior and learn to reframe or rethink their circumstances. As "self-talk" becomes more positive and as behavior changes, affect becomes more positive. Generally, a reflective, nondirected approach to a depressed adolescent reinforces the depression and is to be avoided.
2. As discussed previously, most suicidal adolescents engage in one or several distortions of their thinking patterns. They need assistance with this aspect of their day-to-day functioning.
3. Behavioral models approach change through a sequential, achievable series of steps or stages. Emphasis is placed on altering behavior which can be identified

and monitored. Clients experience a growing sense of achievement and control when the helper plans a treatment strategy which enables the client to observe improvement and change. Since suicidal adolescents are usually overwhelmed by a feeling of helplessness and hopelessness, a cognitive-behavioral frame of reference during counseling assists the client with the process of empowerment and regaining or developing better control of self and environment.

4. Suicidal adolescents are not good at problem solving. They view options rigidly and may not be skilled at analyzing the consequences of choices. They need to be stimulated with new information to use in the process of easing the pain they currently experience. Since cognitive-behavioral models usually require the counselor to teach, structure and describe behavior to be practiced, or new, more positive self-statements to be learned, the problem solving capacity of the suicidal adolescent often undergoes steady improvement.
5. As previously discussed, suicidal adolescents are often low in self-esteem and are other-directed. In counseling such an adolescent will usually follow the lead of a professional who presents a structured, systematic and directed approach to the counseling experience. Initially, this natural tendency is an asset in the process of achieving better mental health. The ultimate goal of counseling, of course, is to foster higher self-esteem, increased inner-directedness and independence.

The selection of a specific cognitive-behavioral model as a framework for the counseling or therapy process is the responsibility of the counselor. The publications of Albert Ellis (1979), John Krumboltz and Carl Thoresen (1976) and Arnold Lazarus (1976) present possibilities for counselors to consider in working with suicidal adolescents. The American Association of Suicidology's journal, *The Journal of Suicide and Life Threatening Behavior*, is an additional invaluable resource.

Intervention Strategies

A number of guidelines can be suggested to anyone providing counseling for the purpose of preventing a suicidal (or potentially suicidal) adolescent from making an attempt. These guidelines should be followed regardless of the specific intervention strategies chosen by the counselor or therapist in conjunction with a counseling or treatment plan.

1. **Be calm, reassuring and supportive.** Remember that adolescents at risk for suicide may be experiencing considerable pain and turmoil and are always low in self-esteem. A calm, reassuring and supportive manner conveys interest and respect and does not further damage fragile ego integrity.
2. **Encourage self-disclosure.** The very act of sharing the internal pain experienced by a potentially suicidal adolescent is an initial, important step in the long-term counseling process. The professional helper may be one of the first adults with whom such an adolescent has been willing to share and to trust. Catharsis is a first step in the healing process. In addition, the information gained by the counselor is necessary for making an initial assessment of the client and developing a treatment plan.
3. **Be nonjudgmental.** Even though the circumstances described by an adolescent may seem manageable to the counselor, it is important for the counselor to accept the fact that, to this adolescent client, the circumstances may seem insurmountable. The same recommendation should be applied to the adolescent's expression of feelings, whether they are feelings of helplessness, apprehension, depression, frustration or numerous other painfully experienced emotions. The situation as perceived and the feelings as experienced are reality for the client and must be respected. Judgmental responses ("you should not feel as you do" or "you should have known better than to. . . .") serve to lower already impaired self-esteem and decrease willingness to communicate. Such client responses are the opposite of what interventions should be designed to achieve.
4. **Provide acknowledgment and normalize the reality of suicide as a choice, but encourage exploration of other alternatives to problem solving:** "It is not unusual for adolescents to feel so badly that thoughts of suicide begin to recur more and more often. I'm glad you are talking with me about your feelings so we can begin to explore other ways to view your circumstances and respond to those around you."
5. **Acknowledge the adolescent's internal pain.** Nothing makes an adolescent feel more understood and accepted than the experience of hearing an adult convey understanding of how difficult day-to-day coping can be. Remember that potentially suicidal adolescents find it difficult to express feelings and share thoughts. The feeling of relief that occurs when a professional communicates an understanding of what has been shared facilitates the counseling

process by encouraging self-disclosure and engendering an increased self-confidence.

6. **Begin problem solving unless the adolescent is in a crisis situation.** It is very important for the suicidal adolescent to begin to overcome feelings of helplessness and hopelessness and to develop a sense of control as soon as possible. Developing a counseling or treatment plan which is shared with the client is extremely important. Care should be taken to develop a plan which will enable the client to take control of his/her life through a sequenced series of achievable goals; experiencing success and accompanying feelings of pride can be empowering and lead to an enhanced level of self-esteem. Problem solving counseling, however, will not be successful if it is initiated while the adolescent is in a crisis situation. The stress, emotional turmoil and cognitive distortions experienced during a crisis period make "counseling" inappropriate and "management" of the client necessary.

Prevention Strategies for Schools and Communities

Components of school-based programs. Six components of school-based suicide prevention programs must be in place for the adolescent "at risk" population: (1) district and building level administrative support; (2) faculty/staff inservice on the topic of adolescent suicide; (3) parent education on the topic of adolescent suicide; (4) classroom presentations for all adolescents; (5) preparation of core teams; and (6) options for individual and group counseling.

District and building level administrative support. For any adolescent suicide prevention program to be successful, it is essential to garner the support of district and building level administrators prior to the planning, initiation or evaluation of the program. The superintendent, assistant superintendent, curriculum director, staff development director, student services coordinator, research and evaluation specialist, as well as all building principals and vice principals should understand the importance of suicide prevention efforts and commit their support prior to the initiation of a program. These recommendations are based on the experience of this author in the process of working with school districts all over the country. The impact is greater, the efforts are better funded, and the program is put more permanently in place when the initiator (consultant, counselor, student services coordinator, etc.) organizes a meeting with district and building level

administrators while efforts are being considered and planned. This is the only way to obtain funding and commitment for inservice, parent education, classroom guidance, preparation of core teams, and options for individual and group counseling. When administrators have the opportunity to listen to an overview of proposed efforts and ask questions, a higher level of commitment can be established so that plans can be expedited.

Faculty/staff inservice on the topic of adolescent suicide. It is extremely important for *all* faculty and staff (teachers, aides, secretaries, administrators, custodians, food service personnel, etc.) to be included in building and/or district level inservice on the topic of adolescent suicide. Teachers and other faculty and staff are often the first to learn about the circumstances of an adolescent at risk for suicide. If they understand the profile, the myths, and the organization of school building and district level prevention efforts, they can refer to the school counselor, social worker, nurse or psychologist and possibly remain strategically involved in prevention efforts. In addition, it is essential that all the adults in a given school building be educated about both adolescent suicide and the approach being taken to prevention so that when students in the school reach out for assistance, the adults have a clear understanding and a degree of self-confidence about what they should (*and should not*) do. When middle school and high school students participate in educational programs at the classroom level on the topic of adolescent suicide, they begin to realize that some of their friends (or they, themselves) are at risk and approach admired school personnel. *It is unethical not to prepare school faculty and staff in advance of the presentation of information on suicide to the students in a school.* Adults who are apprehensive or threatened by the topic cannot respond and act constructively when a suicidal adolescent reaches out for assistance.

Parent education on the topic of adolescent suicide. The parents of students in a given school building have a right to understand the purpose and components of a school's adolescent suicide prevention program. In addition, they experience the same information needs and the same apprehensions as the faculty and staff of the school prior to the faculty/staff inservice efforts. Although parent education programs do not have to be as detailed and lengthy as the inservice offered to school employees, prevention efforts will more likely succeed if parental understanding and support is developed. Again, it is important to involve parents in such educational efforts prior to presenting information to students.

Classroom presentations for all adolescents. There has been much debate (and little research) on the efficacy of prevention programs which include presentations on the topic

directly to adolescents in the schools. Attitudes and apprehensions in this regard bear similarity to the attitudes and apprehensions that surfaced ten or fifteen years ago when schools first began providing faculty/staff inservice and classroom presentations on the topic of physical and sexual abuse. Currently, there are a number of advocates of suicide prevention efforts via presentations and discussions with students (Capuzzi, 1986; Capuzzi & Golden, 1988; Curran, 1987; Ross, 1980; Sudak, Ford, & Rushforth, 1984). Unless school faculty provide students with a forum for accurate information on adolescent suicide and direction in their efforts to seek help and assistance, students may rely on inadequate information and/or misinformation. As mentioned earlier in the discussion of myths, encouraging adolescents to ask about or discuss the topic of suicide does not provide license to make an attempt. Since media coverage of individual and cluster suicides does not usually include adequate educational components, and since many television movies on the topic "romanticize" the act of suicide, it is essential that our schools accurately, empathically and directly address the issue. Students in American schools frequently have indirect experience with suicide through the actions of a peer group or family member. They have questions about themselves as well as their friends. A well-planned and sequenced classroom presentation by a competent presenter who has participated in the development of the school's prevention program is essential. Such a presentation should include some of the same information provided to school faculty and staff and parents as well as information about where, in the school, to seek assistance and what to do if a friend seems to be thinking about suicide.

Preparation of core teams. Many school buildings have "core teams" composed of some combination of teachers, counselors, social workers, psychologists, parents and, perhaps, administrators. These teams usually exist in the context of an intervention program for substance use and abuse. Almost all of these teams have been educated about the traits that place adolescents at risk for using and abusing alcohol and other drugs. These traits are similar to the ones which put adolescents at risk for suicide. With some additional training, core team members can be invaluable in all aspects of prevention in a school-based program as well as contributors to crisis management and postvention efforts.

Options for individual and group counseling. It is extremely important to encourage those students at risk for attempting suicide to avail themselves of the services of the school counselor. All of the guidelines suggested earlier can be applied to the process of encouraging such adolescents to explore the parameters of low self-esteem, feelings of hopelessness and helplessness, isolation, stress and guilt. Reasons for being other-

directed, needing to act out or achieve for compensatory purposes, or relying on decision making which is either other-directed or skewed because of cognitive distortions, should all be explored with a long-term goal of overcoming these barriers to positive mental health.

Two additional points need to be addressed. First, working with the potential suicidal adolescent requires a long-term commitment on the part of school personnel. No counselor, psychologist or social worker can undo the experiences, perceptions and feelings of a lifetime during a few, short counseling sessions. For anyone connected with an educational system to have such expectations is unrealistic. This means that a counselor's time must be freed to work on a long-term, intensive basis with students in need of these preventive interventions. If a school system is not willing to make such a commitment, then the possibility of contracting with outside agencies should be considered. It does not make sense to initiate a prevention program if it is not possible to assist students with their concerns once they have been encouraged to reach out for help. Second, research, especially in the area of group counseling with suicidal adolescents (Curran, 1987), is poorly developed. Any school which designs and executes a prevention program should include an evaluation component so that the available database may be improved.

Components of community-based programs. The components of community-based programs, such as those found in mental health centers, psychiatric units of hospitals, clinics and groups of professionals sharing a private practice, are similar in many respects to the components needed in a school-based prevention program. There must be commitment to involvement in community efforts focused on adolescent suicide prevention if the employees in an agency are to participate. In addition, all mental health counselors, psychologists, social workers, etc., must be totally aware of the parameters of the adolescent suicide problem as well as the particular characteristics and dynamics of the presuicidal adolescent. Practitioners who have not had prior preparation in these areas will need to have continuing education or staff development experiences on the topic. Conducting community education sessions for adults and adolescents, as well as providing individual and group counseling or therapy is also essential.

Community-based programs must also address the components of crisis management and postvention efforts so necessary for effective intervention strategies with suicidal individuals and *must be available* for liaison work with local schools. These three topics are addressed in the following discussion of crisis management and postvention.

Crisis Management

When an adolescent has been identified as potentially suicidal, every attempt should be made to refer the adolescent to a professional counselor so that preventive steps can be taken immediately. There are many circumstances, however, in which the adolescent at risk for a suicide attempt is not identified until the adolescent is in a crisis state. In such circumstances it is imperative to initiate action without delay so that both lethality and follow-up options can be assessed. Many professionals who lack experience with adolescents who are having a personal crisis do not realize the necessity of approaching such an adolescent in a manner that is simultaneously decisive and reassuring and supportive. When thinking about crisis management it is helpful to think about the meaning of the word "crisis" as well as the meaning of the word "management." The term "crisis" means that the situation is not usual or normal; circumstances are such that the individual involved is highly stressed and in need of assistance. Adolescents in crisis may be feeling helpless, vulnerable, at a loss for how to cope, stressed, angry and belligerent, and very low in self-esteem. The term "management" means that the adolescent caught in the crisis situation must be directed, monitored and guided in order to prevent an act of or attempt at self-destruction because of the degree of emotional pain and impulsiveness which has become, for the time being, the most prominent of realities. It should also be noted that adolescents experiencing a suicidal crisis may be quite volatile and lethal to self for a one-to-three day period; therefore, the need for rapid, decisive intervention cannot be overemphasized. This means that mental health practitioners, whether in school or agency settings, will have to cancel previously made plans and appointments from the time the adolescent in question is brought to their attention until some resolution of the crisis has been effected. A delay in responding to an adolescent at risk for suicide, or a lack of willingness on the part of the helper to change the preplanned routine of the day, could mean the loss of a life.

Assessing Lethality

A number of steps should be taken when called upon to assist an adolescent who seems to be in a suicidal crisis. The severity of the crisis and the lethality or risk the adolescent presents to his or her own personal safety must be evaluated immediately.

Contact another professional. Always enlist the assistance of a qualified colleague when presented with an adolescent thought to be in the midst of a suicidal crisis.

School counselors should ask a member of the school's core team or a colleague who has been trained in the school's inservice program on suicide prevention. Mental health counselors or private practitioners should also enlist the assistance of a colleague with an understanding of the inter- and intra-personal dynamics of the suicidal adolescent as well as the precepts of crisis management. It is always better to have the support and additional perceptions and observations a colleague can provide in such a situation. Remember, this could be a life-or-death situation if the crisis is judged to be severe. Remember, also, that liability questions are less likely to become issues and professional credibility less likely to be questioned if assessment of lethality or risk and subsequent recommendations for crisis management have been made on a collaborative basis.

Develop as much rapport as possible. Basic guidelines for working with suicidal adolescents were described earlier (a calm, reassuring supportive manner; encouragement of self-disclosure; the importance of being nonjudgmental; acknowledgment of the reality of suicide as a choice while encouraging the exploration of other alternatives) and should be adhered to during the process of assessing lethality. These guidelines are based on what is known about the internal dynamics of the suicidal adolescent and are conducive to establishing the rapport and trust necessary for crisis management efforts to be successful. Remember, also, that you may be one of the first or the only adult that the adolescent has had the courage to talk to about suicidal preoccupations and circumstances. Since low self-esteem and poor communication ability make this kind of self-disclosure difficult, it is important for the helping person to be viewed as competent and respectful at the same time.

Ask questions to assess lethality. A number of areas need to be explored to assess lethality. This can be accomplished most appropriately through an interview format (a crisis situation is not conducive to the administration of an appraisal instrument). The following questions help determine the degree of risk; all of them do not need to be asked if the assessment interview results in the spontaneous provision of the information:

- *"What has happened to make life so difficult?"* The more an adolescent describes the circumstances that have contributed to feelings of despair and hopelessness, the better opportunity for effective crisis management. The very act of describing stress-producing interpersonal situations and circumstances may begin to lower the feelings of stress and reduce risk. It is not unusual for an adolescent in the midst of a suicidal crisis to describe a multifaceted set of problems with family, peers,

school, drugs, etc. The more problems an adolescent describes as stress-producing and the more complicated the scenario, the higher the lethality or risk.

- *"Are you thinking of suicide?"* Adolescents who are preoccupied with thoughts of suicide may experience a sense of relief to know there is someone who is willing to directly address the issue of suicide. Using the word "suicide" will convey that the helping professional has been listening and is willing to be involved; using the word "suicide" will not put the idea of suicide in the mind of a nonsuicidal adolescent. Obviously, someone who answers "yes" to this question is more lethal than someone who answers "no."
- *"How long have you been thinking about suicide?"* Adolescents who have been thinking intensely about suicide for a period of several weeks are more lethal than those who have had only fleeting thoughts. A good way to explore components of this question is to remember the acronym "FID." When asking about suicidal thoughts, ask about *frequency* or how often they occur, *intensity* or how dysfunctional the preoccupation is making the adolescent ("Can you go on with your daily routine as usual?"), and *duration* or how long the periods of preoccupation last. Obviously, an adolescent who reports frequent periods of preoccupation so intense that it is difficult or impossible to go to school, to work, or to see friends, and for increasingly longer periods of time so that periods of preoccupation and dysfunction are merging, is more lethal than an adolescent who describes a different set of circumstances.
- *"Do you have a suicide plan?"* When an adolescent is quite specific about the method, the time, the place and who will or will not be nearby, the risk is higher. (If the adolescent describes use of a gun, knife, medication or other means, ask if he or she has that item in a pocket or purse and request that the item be left with you. Never, however, enter into a struggle with an adolescent to remove a firearm. Call the police or local suicide center.) Most adolescents will cooperate with you by telling you about the plan and allowing you to separate them from the means. Remember, most suicidal adolescents are other-directed; these traits should be taken advantage of during a crisis management situation. Later, when the crisis has subsided and counseling is initiated, the adolescent's internal locus of control can be strengthened.
- *"Do you know someone who has committed suicide?"* If the answer is "yes," the adolescent is of higher risk especially if this incident occurred within the family

constellation or a close network of friends. The adolescent may have come to believe, as a result, that suicide is a problem solving option.

- *"How much do you want to live?"* An adolescent who can provide few reasons for wishing to continue with life is of higher risk than an adolescent who can enumerate a number of reasons for continuing to live.
- *"How much do you want to die?"* The response to this question provides the opposite view of the one above. An adolescent who gives a variety of reasons for wishing to die is more lethal than an adolescent who cannot provide justification for ending life.
- *"What do you think death is like?"* This question, like the others, is an excellent one for assessment purposes. Adolescents who do not seem to realize that death is permanent, that there is no reversal possible, and that they cannot return are at higher risk for an actual attempt. Also, adolescents who have the idea that death will be "romantic," "nurturing," or "the solution to current problems" are at high risk.
- *"Have you attempted suicide in the past?"* If the answer to this question is "yes," then the adolescent is more lethal. A second attempt may occur which could be successful because a previous attempter has the memory of prior efforts and the fact that he or she conceptualized and carried through with a suicide plan. An additional attempt may correct deficits in the original plan.
- *"How long ago was this previous attempt?"* is a question that should be asked of any adolescent who answers "yes" to the previous question. The more recent the previous attempt, the more lethal the adolescent.
- *"Have you been feeling depressed?"* Since a high percentage of adolescents who attempt or complete suicide are depressed, this is an important question. Using the acronym FID to remember to ask about frequency, intensity and duration is also helpful in the context of exploring an adolescent's response to this item. As discussed earlier, a determination needs to be made relative to the existence of clinical depression if such a condition is suspected. Adolescents who report frequent, intense and lengthy periods of depression resulting in dysfunctional episodes which are becoming closer and closer together, or are continuously experienced, are at high risk.
- *"Is there anyone to stop you?"* This is an extremely important question. If the adolescent has a difficult time identifying a friend, family member or significant

adult who is worth living for, the probability of a suicide attempt is high. Whoever the adolescent can identify should be specifically named and addresses, phone numbers and "relationship" to the adolescent should also be obtained. (If the adolescent cannot remember phone numbers and addresses, look up the information, together, in a phone book.) In the event it is decided that a suicide watch should be initiated, the people in the network of the adolescent can be contacted and asked to participate.

- *"On a scale of one to ten, with one being low and ten being high, what is the number that depicts the probability that you will attempt suicide?"* The higher the number, the higher the lethality.
- *"Do you use alcohol or other drugs?"* If the answer to this question is "yes," the lethality is higher because use of a substance further distorts cognitions and weakens impulse control. An affirmative response should also be followed by an exploration of the degree of drug involvement and identification of specific drugs.
- *"When you think about yourself and the future, what do you visualize?"* A high risk adolescent will probably have difficulty visualizing a future scenario and will describe feeling too hopeless and depressed to even imagine a future life.

As noted at the beginning of this discussion, it is not necessary to ask all of these questions if the answers to them are shared during the course of the discussion. It should also be noted that the interviewing team must make judgments about the truthfulness of a specific response by considering the response in the total context of the interview.

Crisis Management Interventions

If, as a result of an assessment made by at least two professionals, suicide is an option under consideration by a given adolescent, a number of crisis management interventions can be considered. They may be used singly or in combination; the actual combination will depend upon the lethality determination, resources and people available, and professional judgment. It is the responsibility of the professionals involved, however, to develop a crisis management plan to be followed until the crisis subsides and long-term counseling or therapy can be initiated.

Notification of parents. Parents of minors must be notified and asked for assistance when a minor is determined to be at risk for a suicide attempt. At times, adolescents may attempt to elicit a promise of complete confidentiality from a school or

mental health counselor who learns about his or her suicidal intent. Such a promise, as discussed earlier, is not possible; the welfare of the adolescent is the most important consideration and parents should be contacted as soon as possible.

At times, parents may refuse to believe that their child is suicidal and may not agree to leave home or work and meet with their son or daughter and members of the assessment team. In addition, they may be adamant in their demands that the school or mental health professional withdraw their involvement. Although such attitudes are not conducive to management of a crisis situation, they are understandable since many parents may respond to such news with denial or anger to mask their true emotions and apprehensions that perhaps their child's dilemma reflects their personal inadequacies as people and as parents. Since an adolescent at risk for a suicide attempt cannot be left unmonitored, this provides a problem for a school or mental health agency. To conform to the wishes of noncooperative parents places the adolescent at even greater risk. Steps must be taken despite parental protests. Although some professionals may worry about liability issues in such circumstances, liability is higher if such an adolescent is allowed to leave unmonitored and with no provision for follow-up assistance. Schools and mental health centers should confer with legal counsel to understand liability issues and to make sure best practices are followed. Action, however, must be taken even if parents fail to provide support.

Considering hospitalization. Hospitalization may be the option of choice during a suicidal crisis (even if the parents are cooperating) if the risk is high enough. An adolescent who has not been sleeping or eating, for example, may be totally exhausted or highly agitated. The care and protection that can be offered in a psychiatric unit of a hospital may be needed until the adolescent can experience a relief in the pressure and stress that has developed, obtain needed nourishment and sleep, and realize that others do consider the circumstances painful and worthy of amelioration. In many hospital settings, multidisciplinary teams (physicians, psychiatrists, counselors, social workers, nurses, nurse practitioners, teachers) work to individualize a treatment plan and provide for out-patient help as soon as the need for assistance on an in-patient basis subsides. Such an experience may provide the first step in reducing the alienation from society experienced by an adolescent whose internal pain escalated to the point of culminating in a suicidal crisis.

Writing contracts. At times, professionals may judge that developing a contract with the adolescent, perhaps combined with some other measures, may be enough to help the adolescent through a period of crisis and into a calmer stage during which the adolescent would be receptive to the initiation of long-term counseling or therapy. Such a

contract should be written out and signed and dated by the adolescent. The contract should also be witnessed by the professional helper(s).

Contracts should require the adolescent to:

1. Agree not to harm or attempt to harm self.
2. Obtain enough food and sleep.
3. Discard any item that could be used in a suicide plan (guns, weapons, medications, etc.).
4. Specify the time period covered by the contract.
5. Call a counselor, Crisis Center, etc. if there is a temptation to break the contract.
6. Write down the phone numbers of people to contact if the crisis escalates.
7. Specify ways time will be structured.

Organizing suicide watches. If hospital psychiatric services on an in-patient basis are not available in a given community and those doing the assessment believe the risk is high, a suicide watch should be organized by contacting the individuals that the adolescent has identified in response to the question, "Is there anyone to stop you?" After receiving instruction and orientation from the professional, family members and friends should take turns staying with the adolescent until the crisis has subsided and long-term counseling or therapy has begun. In the opinion of this author, it is not a good idea to depend on a family member alone to carry out a suicide watch; it may be too difficult for family members to retain perspective. Friends should be contacted even though confidentiality, as discussed earlier, cannot be maintained.

Postvention

Coping with the System

When an adolescent has experienced a suicidal crisis, made a suicide attempt, or both, it becomes necessary, especially within the context of a school setting, to assess the impact of such an event or events on the system. Given the networking which occurs within adolescent peer groups, the fact that a student in a given school building has experienced a crisis or made an attempt cannot be kept confidential. This presents a problem since not permitting discussion of the circumstances often encourages sharing of misinformation, and encouraging open discussion may prove embarrassing to the student upon his or her

return to the school and upsetting to the student's parents. Certainly, the first few weeks after a crisis situation is not the time to initiate classroom presentations on the topic of suicide prevention if such a preventive program has not previously taken place. Certain guidelines, however, should be followed that are similar to, but *not* the same as, the ones that should be followed after the completion of a suicide:

1. The building principal should organize a telephone calling network to notify all faculty and staff that a before-school faculty meeting (mandatory) will be held the next morning. The principal should share the facts with school faculty and staff and answer questions they may have.
2. Faculty and staff should be prepared to answer questions about what has happened when they spontaneously arise. Unless faculty and staff have attended the kind of inservice program described earlier, they should not attempt to give answers to questions students may have about suicide in general.
3. Students who have questions about suicide or who may be assuming some of the responsibility for the actions of a suicidal peer should be referred to the school counselor or core team member who can answer questions and also facilitate a discussion of "responsibility" with students who are experiencing guilt.
4. Parents who learn of the situation should be directed to a designated individual or individuals in the school who can answer their questions.
5. Although it is not likely that the media would contact the school about a suicidal crisis or suicide attempt (as might be the case if a suicide completion occurred), this could occur. In such circumstances, the principal should issue a statement to the media and all inquiries made by the media to faculty and staff should be referred to the principal.

Facilitating Follow-Up Counseling or Therapy

Members of school, community and family groups must realize that the return of an adolescent who has experienced a suicidal crisis or made an unsuccessful attempt does not mean that the danger is past and concern can be dropped. The profile of the suicidal adolescent is one that has developed over time in the contexts of family and peer groups, and the need for long-term, intensive counseling is imperative for the recovery of the suicidal adolescent. Caregivers must make sure that counseling begins as soon as the crisis has subsided to the point that counseling can be beneficial. The important thing to

remember is that many adolescents will need considerable time to "heal," build on strengths and overcome deficits developed over time. Schools that cannot provide such counseling need to liaison with agencies and private practitioners who can provide the needed service. It is the responsibility of the professional helper to do everything possible to ensure that counseling takes place and, if necessary, to accompany the adolescent to the first session or two and monitor ongoing progress.

Another dimension of postvention is that as many as six to ten people may be affected, on a long-term basis, for each adolescent suicide attempt or completion. Families may need assistance to develop understanding of what has occurred; peers, teachers and friends may also need it because those around the potential victim so often blame themselves. Practitioners need to consider the possibility of offering family counseling and/or "survivor group" counseling to those indicating the need for help.

Some Final Notations

This author believes it is critically important for readers, prior to involvement with suicidal youth, to seek additional information on the topic of counseling and intervention strategies for working with adolescents at risk for suicide . The references listed at the end of this monograph provide an excellent point of departure. It is equally important to participate in intensive training experiences which detail and expand upon the components of this monograph and provide opportunity for role plays (followed by immediate feedback) of interventions for prevention, crisis management, and postvention with suicidal adolescents. These training experiences should be twelve to fifteen hours in length at a *minimum*. Counselors planning to work clinically with adolescents who have been referred because of possible suicidal intention need to have extensive prior education, supervision, and experience in counseling and human development, with special emphasis on the adolescent stage of human growth and development. Membership in the American Association of Suicidology, participation in workshops and conferences on the topic of suicide prevention, and consistent reading of the *Journal of Suicide and Life Threatening Behavior* and related journals and textbooks are essential.

An adolescent who becomes suicidal is reaching out for help that can be provided only through the helping relationship. Even though our schools are already attempting to deal with far too many problems and responsibilities, and even though our community mental health networks are burdened with far too many clients, we, as a society, cannot fail

to respond to the cry for help from the youth of the 1980s and 1990s. To abdicate our responsibility would communicate a lack of interest in our children and further alienate our youth. The future of our communities, our nation and our world is dependent on a culture composed of healthy members who can cope with the emotional, physical, social and spiritual demands of life in a complex, rapidly changing world.

References

American Association for Counseling and Development. (1981). *Ethical standards*. Alexandria, VA: Author.

American Psychological Association. (1981). *Ethical principles of psychologists*. Washington, DC: Author.

Cantor, P. (1976). Personality characteristics found among youthful female suicide attempters. *Journal of Abnormal Psychology, 85*, 324-329.

Capuzzi, D. (1986). Adolescent suicide: Prevention and intervention. *Counseling and Human Development, 19*(2), 1-9.

Capuzzi, D., & Golden, L. (Eds.). (1988). *Preventing adolescent suicide*. Muncie, IN: Accelerated Development.

Cull, J., & Gill, W. (1982). *Suicide probability scale manual*. Los Angeles: Western Psychological Services.

Curran, D. F. (1987). *Adolescent suicidal behavior*. Washington, DC: Hemisphere Publishing.

Davis, P. A. (1983). *Suicidal adolescents*. Springfield, IL: Charles C. Thomas.

Ellis, A. (1979). The practice of rational-emotive therapy. In A. Ellis & J. Whiteley (Eds.), *Theoretical and empirical foundations of rational-emotive therapy* (pp. 61-100). Monterey, CA: Brooks/Cole.

Faigel, H. (1966). Suicide among young persons: A review of its incidence and causes, and methods for its prevention. *Clinical Pediatrics, 5*, 187-190.

Freese, A. (1979). Adolescent suicide: Mental health challenge. USA: Public Affairs Committee, Inc.

Hafen, B. Q. (Ed.). (1972). *Self-destructive behavior*. Minneapolis, MN: Burgess.

Hafen, B. Q., & Frandsen, K. J. (1986). *Youth suicide: Depression and loneliness*. Provo, UT: Behavioral Health Associates.

Hussain, S. A., & Vandiver, K. T. (1984). *Suicide in children and adolescents*. New York: SP Medical and Scientific Books.

Jacobs, J. (1971). *Adolescent suicide*. New York: Wiley-Interscience.

Johnson, S. W., & Maile, L. J. (1987). *Suicide and the schools: A handbook for prevention, intervention, and rehabilitation*. Springfield, IL: Charles C. Thomas.

Kiev, A. (1977). *The suicidal patient.* Chicago: Nelson-Hall.

Kovacs, M., Beck, A., & Weissman, A. (1975). The use of suicidal motives in the psychotherapy of attempted suicides. *American Journal of Psychotherapy, 29,* 363-368.

Krumboltz, J. D., & Thoresen, C. E. (Eds.). (1976). *Counseling methods.* New York: Holt, Rinehart & Winston.

Lazarus, A. (1976). *Multi-modal behavior therapy.* New York: Springer.

Peck, D. (1983). The last moments of life: Learning to cope. *Deviant Behavior, 4,* 313-342.

Ross, C. (1980). Mobilizing schools for suicide prevention. *Suicide and Life Threatening Behavior, 10,* 239-243.

Schneidman, E., Farbverow, N., & Litman, R. (1976). *The psychology of suicide.* New York: Jason Aronson.

Sommes, B. (1984). The troubled teen: Suicide, drug use, and running away. *Women and Health, 9,* 117-141.

Stein, M., & Davis, J. (1982). *Therapies for adolescents.* San Francisco: Jossey-Bass.

Stillion, J., McDowell, E., & Shamblin, J. (1984). The suicide attitude vignette experience: A method for measuring adolescent attitudes toward suicide. *Death Education, 8,* 65-81.

Sudak, H., Ford, A., & Rushforth, N. (1984). Adolescent suicide: An overview. *American Journal of Psychotherapy, 38*(3), 350-369.